Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA RD PASADENA TX 77504-2117	MFDR Tracking #:	M4-09-5608-01
Respondent Name and Box #: Ace American Insurance Co. Box #: 15		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The amount the Carrier paid Vista Hospital of Dallas for the services provided in this case is not fair and reasonable and therefore, not in compliance with the applicable statutes and regulations. Vista Hospital of Dallas charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Hospital of Dallas is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $8,598.95
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers' Compensation Act. In light of the reduced expenses incurred in an outpatient setting, it is unreasonable to pay more for an outpatient procedure or surgery than an inpatient surgery. The Established per diem rate for an inpatient surgical day is set at $1,118.00. The per diem rate for a non-surgical inpatient medical stay is set at $870.00."… "Using these two rates as anchor points, reimbursement is determined based on the amount of time spent in the operating room. Coventry has determined that the provider was not due additional money. It has been determined that Coventry will stand on our original recommendation of $870.00."

Principle Documentation:

1. Response Package
2. EOB

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/27/2008	150, 193, (850-243), (900-030), (900-068), (920-002)	Outpatient Surgery	$8,598.95	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective January 17, 2008 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 150 – "Payer deems the information submitted does not support this level of service."
   - 193 – "Original payment decision is being maintained. Upon review it was determined that this claim was processed properly."

   With additional payment advice codes:
   - (850-243) – "CV: The recommended allowance reflects a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in section 413.011(d) of the Texas Workers' Compensation Act."
     - M – No Mar $0.00
     - M – No Mar $870.00
   - (900-030) – "CV: This charge was reviewed through the clinical validation program"
   - (900-068) – "CV: Additional reconsideration of this bill and submitted documentation does not support additional payment. Recommended final allowance"
   - (920-002) – "In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance."
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, effective January 17, 2008, 33 TexReg 428, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division Rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... This request for medical fee dispute resolution was received by the Division on January 27, 2009. The requestor asks that it be reimbursed "at a minimum, 70% of the billed charges", in support of which the requestor has provided evidence of a managed care contract under which services that are the same or similar to the services in dispute were reimbursed at 70% of billed charges. The requestor states that

   > "This managed care contract exhibits that Vista Hospital of Dallas is requesting reimbursement that is designed to ensure quality medical care is provided and to achieve effective medical cost control. It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services. As a result, the reimbursement requested by Vista Hospital of Dallas is not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract."

   The requestor's position statement further asserts that

   > "The Division has determined that amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code § 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' 'they are relevant to achieving cost control,' 'they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services…"

   While managed care contracts are relevant to determining a fair and reasonable reimbursement, a methodology based on a percentage of billed charges does not, in itself, produce an acceptable payment amount. This methodology was considered and rejected by the Division in the same preamble on which the requestor relies above which states at 22 *Texas Register* 6276 (July 4, 1997) that

   > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of 70% of the billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, reimbursement in the amount of 70% of the provider's billed charges cannot be recommended.

5. The Division would like to emphasize that individual medical fee dispute outcomes rely on evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the additional reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.